DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01-005

2. STATE: Arkansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 12, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.205

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 52,126,998
b. FFY 2002 $ 94,948,009

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19D, Appendix I

Pages ii, 1-2, 1-3, 2-1, 2-2, 2-2a, 2-2b, 2-2c, 2-2d, 2-2e, 2-2f, 2-2g, 2-2h, 2-2i, 3-11 and 3-11a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19D, Appendix I

Pages ii, 1-2, 1-3, 2-1, 2-2, 3-11 (TN 99-009)
Pages 2-3, 2-3a (TN 99-013)
Pages 2-3b, 2-3c (TN 00-003)

10. SUBJECT OF AMENDMENT:

Revisions necessary for implementation of reimbursement methodology change for Nursing Facilities effective January 12, 2001.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Ray Hanley

14. TITLE:
Director

15. DATE SUBMITTED:
March 16, 2001

16. RETURN TO:

Arkansas Division of Medical Services
PO Box 1437 Slot 1103
Little Rock, AR 72203-1437

Attention: Binnie Alberius

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 03-22-2001

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
12 JANUARY 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
CALVIN G. CATLIN

22. TITLE: ACTING REGIONAL ADMINISTRATOR
DIV. OF MEDICAID AND STATE OPERATIO

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

2. Payment Method

3. Allowable Costs

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SUPERSEDES: AR-99-09

1-3 Activities Not Related to Resident Care

If the provider conducts activities not related to resident care, additional accounts must be added to accommodate those activities.

1-4 Accrual and Cash Basis of Accounting

For non-governmental providers, the Financial and Statistical Report must be filed using information stated on the accrual method of accounting. The Chart of Accounts is designed to be used in a complete accrual accounting system.

Financial information stated on an accrual basis is essential to insure that the proper reimbursement is made to providers. The measurement of the cost of services performed must include all supplies, salaries, services and other expenses incurred, regardless of whether or not those items have been paid.

Many providers will find that the accounting for all transactions on a pure accrual basis may create undue workloads. Also, many providers account for their activities on a strict cash basis and they are satisfied with the management information produced from their existing system. Therefore, in lieu of accounting for all transactions on an accrual basis, the provider may maintain his records on a cash basis during the year and convert to an accrual basis at the beginning and end of the year for reporting purposes.

1-5 Chart of Accounts

The applicable Chart of Accounts shall be used by all Long Term Care Facilities participating in the Title XIX Program. Each Chart of Accounts provides for the basic classifications of all assets, liabilities, income and expense necessary for the preparation of the Cost Report. Providers may take some latitude in assigning account numbers but must maintain the basic Chart of Accounts.

1-6 Cost Reporting Requirements

All providers in operation under a valid Medicaid agreement for long term care services must file a Financial and Statistical Report (commonly referred to as a Cost Report or FSR). In addition to the annual reporting requirement nursing facilities will be required to submit a limited cost report containing direct care cost information for the period January 12, 2001 to June 30, 2001, in order that the direct care per diem can be rebased after this initial period. Nursing facilities that are either new or have changed ownership or are new to the program will be required to prepare and submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation. This report is essential in establishing rates for a new provider. If the facility was not certified for Medicaid participation at date of first

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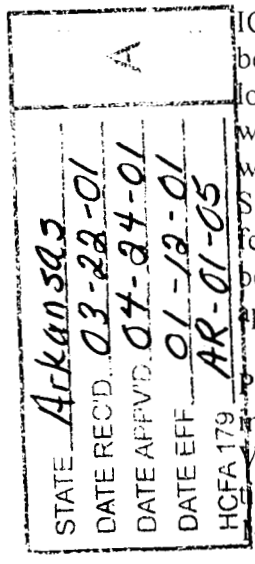
opening or acquisition, then the reporting period shall begin at official certification date rather than the date of acquisition.

A. When To File

Nursing facilities will report cost on a fiscal year ending June 30. Cost reports will be due within 75 days after the end of the reporting period. Under 16 Bed ICF/MR providers will report cost on a calendar year basis. The cost report will be due within 90 days of the end of the reporting period. Benton Nursing Facility located at the Benton Services Center and the 16 Bed and over ICF/MR providers will report cost semi-annually (January 1 - June 30) and (July 1 - December 31) with the cost reports being due the second Tuesday of February and August. Should the due date fall on a Saturday, Sunday, or State of Arkansas holiday or federal holiday, the due date shall be the following business day. Reports are to be delivered to the Office of Long Term Care or postmarked on or before the applicable due date.



Providers who fail to submit cost reports and other required schedules and information by the due date or extended due date have committed a Class D Violation of Arkansas Code 20-10-205. Civil penalties associated with failure to timely submit a cost report for Long Term Care Facilities are detailed in Section [illegible]-11 of this Manual.

B. Extensions for Filing

If a written request for an extension is received by the Office of Long Term Care ten or more working days in advance of the report due date and a written extension is granted, a penalty will not be applied, provided the extended due date is met. Each request for extension will be considered on its merit. No extension will be granted unless the facility provides written evidence of extenuating circumstances beyond its control, which causes a late report. In no instance will an extension be granted for more than 30 days.

C. What to Submit

In addition to the applicable cost report forms, providers must submit the following:

1. Most recently completed Medicare Cost Report,

2. Working trial balance and related working papers identifying the cost report line each account is included on,

3. Detailed depreciation schedule,

4. Any work papers used to compute adjustments made on the cost report,

Chapter 2 - Payment Method

Federal law requires that states use published payment methodologies and justifications which specify comprehensively the methods and standards for making Medicaid provider payments to long term care facilities.

2-1 Assurance of Payment

Certified Title XIX Long Term Care Facilities furnishing services in accordance with all state and federal Medicaid laws and rules will be paid in accordance with rates established under the state Medicaid plan.

2-2 Acceptance of Payment

Participation in the Title XIX Program is limited to those Facilities which agree to accept the Medicaid payment as payment in full for all care services provided to Medicaid recipients.

2-3 Upper Limits based on Customary Charges

In no case may the reimbursement rate for services provided under this plan exceed an individual facility's customary charges to other third party payers for such services, except for those public facilities rendering such services free of charge or at a nominal charge.

A facility will be given a period of 60 days after notification of a Medicaid rate increase to implement any required increase to other residents. If the Medicaid increase is effective retroactively, the facility will not be required to collect increases retroactively from other residents.

2-4 Facility Class

The Department has established the following specific payment methods:

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A. Nursing Facilities

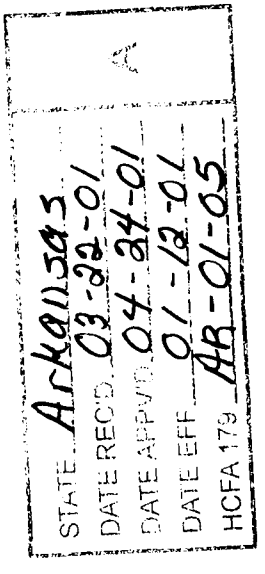
1. Reimbursement Methodology

Reimbursement rates for nursing facilities will be cost-based, facility-specific rates that will consist of four major cost components and will be determined in the following way.

Reimbursement rates will be determined by adding calculated per diem amounts for four separate components of cost: Direct Care, Indirect, Administrative, and Operating, Fair Market Rental, and the Quality Assurance Fee. This cost data for calculating these per diems will be taken from desk reviewed cost reports submitted by providers in accordance with these regulations. Only full-year cost reports will be used in establishing cost floors and ceilings. The methodology for calculating the per diem amounts for each component of cost is provided below:

A. Direct Care

Direct care per diem cost shall be calculated from the facility's actual allowable Medicaid cost as reported on the facility's cost report. The direct care per diem cost is subject to a floor and a ceiling.



The floor shall be 90% of the median arrayed allowable Medicaid direct care cost per diems per facility cost reports. Providers that report allowable direct care per diem cost less than the established floor will be paid the floor in their per diem rate. The purpose of the floor is to provide those facilities that have not been spending at least a minimal amount of monies in the direct care area additional cash flow to assist them in increasing expenditures. The use of a floor will expire July 1, 2004. This will allow providers more than three full years to increase direct care spending. Facilities that fail to incur a direct care cost per diem at the established floor adjusted for inflation will be required to repay the difference between the inflation index (see section A. 5.) adjusted floor and actual cost for the corresponding rate period.

The ceiling shall be established at 105% of the allowable Medicaid direct care cost per diem incurred by the facility at the 90th percentile of arrayed Medicaid direct care facility cost per diems.

The state will rebase the direct care per diem rate after an approximate six-month reporting period January 12, 2001 to June 30, 2001 and again at the end of the first annual reporting period. The direct care

component of the rate will rebase annually for the period July 1st to June 30th. An inflation index will be applied to the provider's direct care per diem cost to inflate cost from the cost reporting period to the rate period.

B. Indirect, Administrative, and Operating

For initial rate setting, the per diem payment for this component will be set at 110% of the median indirect, administrative, and operating per diem cost adjusted for inflation using the inflation index (see Section A. 5.) and paid as a class rate to all facilities. This per diem payment will be rebased at least once every three years. For rate periods in which the indirect, administrative, and operating cost component is not rebased, the existing indirect, administrative and operating per diem will be inflated forward into the next rate period using the inflation index. For each year in which costs are rebased, the per diem will be calculated in the same manner as used in the initial rate setting process.

C. Fair Market Rental

A fair rental system will be used to reimburse property costs. The fair rental system reduces the wide disparity in the cost of property payments for basically the same service therefore making this payment fairer to all participants in the program. The fair market rental system will be used in lieu of actual cost and/or lease payments on land, buildings, fixed equipment and major movable equipment used in providing resident care. The fair rental payment for facilities that are leased from a related party will be calculated from the costs associated with the related party in conformity with related party regulations.

The payment for provider property cost will be calculated annually by adding the return on equity, facility rental factor, and the cost of ownership, and dividing the sum of these three components by the greater of the actual resident days or resident days calculated at the following occupancy levels for the cost reporting period indicated:

Year 1 (SFY 2002)	75%
Year 2 (SFY 2003)	75%
Year 3 (SFY 2004)	81%
Year 4 (SFY 2005) and beyond	85%

Resident days at the minimum occupancy level are calculated as: *Total Licensed Beds x Number of Days in the Period x Minimum Occupancy Percentage.*

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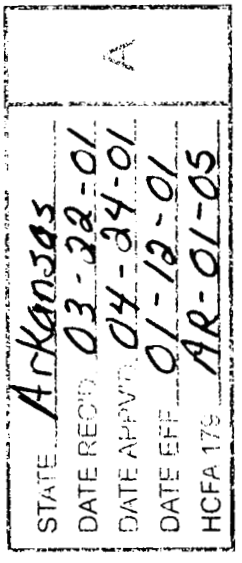
(Rates for the initial rate period January 12, 2001, to June 30, 2001, will be calculated using an occupancy level of 75%).

1. Return on Equity

The return on equity portion of the fair market rental payment will be calculated by taking the Current Asset Value (CAV) of a facility less the ending loan balance on any loans used to finance fixed assets or major movable equipment, times the sum of the June 30th, 30 year U.S. Treasury Bond Yield plus 1.5% as a risk premium. For purposes of calculating return on equity and determining allowable interest expense, allowable debt cannot exceed the facilities Current Asset Value. The maximum Treasury bond yield rate used for calculating return on equity will be 10%.

The Current Asset Value (CAV) of a facility is calculated by multiplying the number of beds in a facility by the Per Bed Valuation (PBV) less an aging index of 1% for each year of age, not to exceed a 50% reduction in PBV. A facility will be considered new the cost reporting period in which the facility is licensed. A facility will be considered one year old the following cost reporting period. The CAV of a facility will be recalculated and an appropriate adjustment to the per diem will be made when additional beds are placed in operation.



The Per Bed Valuation (PBV) will be determined by the current cost of constructing and equipping one nursing facility bed, which has been determined to be $38,000 for the cost report period ending June 30, 2000. The $38,000 per bed value was identified as the average construction cost of recently constructed facilities. The PBV will be adjusted annually thereafter to reflect changes in construction costs as indicated per the Marshall Valuation Service. A percentage increase will be calculated by dividing the difference between the Comparative Cost Multipliers construction index for Little Rock, Arkansas, for the quarter ending January of the cost reporting period and January of the previous year. The annual adjustment percentage will be the lessor of the percentage as calculated above for building classes:1) Masonry Bearing Walls, 2) Wood Frame, or 3%.

2. Facility Rental Factor

A facility rental factor will be paid for each facility. The rental factor is calculated by multiplying the CAV of the facility by 2.5%.

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3. Cost of Ownership

The cost of ownership component of the property payment will consist of interest, property taxes, and insurance (including professional liability and property) as identified on the facilities cost report. The limitation on allowable interest expense is addressed in the return on equity calculation described above.

4. Minor Equipment Purchases

The cost of purchases of minor equipment is not covered in the Fair Market Rental Payment. Minor equipment for the purposes of reimbursement is any equipment that has a unit cost of $300.00 or less that would not have been included in the initial construction and furnishing of the facility. Minor equipment purchases are to be expensed in the cost area in which the equipment is normally used. Group purchases of minor equipment either in a single purchase or through periodic purchases throughout the reporting year are no longer considered minor and reimbursement is considered to have been included in the providers Fair Market Rental Payment.

5. Renovations

The current asset value of a facility will be adjusted as a result of major renovations made to an existing facility. A major renovation is defined as renovations made to a facility where the total per bed cost of the renovation equals or exceeds ten percent (10 %) of the facility's current per bed value for the beds renovated or five (5%) for renovations to common areas. The actual cost of all additions or fundamental alterations to a facility that are required by state or federal laws or rules that take effect during the cost reporting period will be treated as an adjustment to the provider's aging index regardless of the percentage of current per bed value. The cost of renovation will be treated as an adjustment to the provider's aging index. A facility's aging index will be reduced by one percent (1%) for each percent of the current per bed value expended for renovations on a per bed basis. For facilities that have beds that have been placed in operation at different times or when renovations include only a portion of the beds in a facility, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will relate to only those beds that were included in the renovation. For renovations to common areas, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will be applied proportionally to all beds.

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